AHCCCS

AHCCCS is Arizona's Medical Assistance Program (Medicaid)

Request for Verification Of Employment

Customer:	AHCCCS ID:	Customer #:
	Date:	
	Eligibility Specialist:	
	Phone: ( ) -	
	Fax: ( ) -	

I give you permission to give AHCCCS the information asked for below by mail, telephone, or fax. This permission ends one year after the date I sign this form.

Signature:	Date:	Name of Employee:	Social Security Number

Please answer all questions and return this form in the enclosed envelope **WITHIN 10 DAYS** from the date shown above. This information is needed to decide if the person(s) can qualify for AHCCCS Health Insurance. The information you give us will be kept confidential except when we are required by law to release the information.

1. What is the date this employee was hired?	2. What date did employment end? What was the date and amount of last paycheck?

3. Please list all **gross** earnings (before deductions) **paid** to the employee for the months listed. List each paycheck separately by date **paid.**

Month/ Year	Pay Period Ending	Date Paid	Gross Earnings	Hours	Tips (not included in gross)	Month/ Year	Pay Period Ending	Date Paid	Gross Earnings	Hours	Tips (not included in gross)

4. If this employee receives any commissions, bonuses, or flex income credits that are not included in the gross amount above, please list the amount, date paid, and frequency of payment.

5. How often is this employee paid? ☐ Weekly ☐ Every two weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Other:

6. What is this employee's hourly wage?	7. What is the employee's hourly overtime wage?

8. If the employee is paid overtime, what is the average number of overtime hours worked per pay period?

9. If the number of hours worked or the rate of pay is expected to be different from what is listed above in the next 6 months due to any of the following, please provide the reason for the expected change and explain: ☐ Overtime ☐ Shift Differential ☐ Tips ☐ Commissions ☐ Bonuses ☐ Salary Increase ☐ Unpaid Leave ☐ Seasonal Change ☐ Reimbursements for gas, uniforms, mileage, etc. ☐ Other:

10. Are Social Security taxes and Medicare taxes withheld from the employee's wages? ☐ Yes ☐ No

11. If the employee's family is currently covered by health, dental or vision insurance, please provide the following information. Also provide this information if they are not currently covered, but were covered within the last 3 months.

Insurance Company Name:	Phone Number: ( ) -	Policy Number:
Dependents Covered:		

Effective Date:	Termination Date:	Reason for Termination:
Premium:	If amount of premium is expected to change, when is the change expected to occur (mo/yr)?	

Company Representative's Signature:	Title:	Phone Number:	Date: